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Mental Health in France, Policies and Actors: towards a more open Administration

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SUMMARY :

The new mental health care policy which has been set up in France has involved a change of paradigm which has been going on since the 2000s: the emphasis is shifting from psychiatry to mental health care. This shift focuses mainly on the way knowledge about mental health is produced and circulates among an increasingly large number of bodies (including patients' families' associations). Mainly grounded on actors interviews analysis, official reports and blue prints, the study shows that the results of this process are numerous. They include the development of ambulatory care, a strong move towards decentralization and the increasing use of new public management tools. More data and knowledge are therefore to be shared in this more complex system. However, the French state, in the form of the central administration, is taking advantage of this move and is still importantly contributing in the definition and the implementation of the new policy.

Keywords:

France, public action, mental health, new public management, knowledge, health policy

INTRODUCTION

Upon examining public health policies in a highly centralized system such as the French system, which has a strong "administrative tradition", it can be seen that the fact that the system is gradually integrating new actors and new knowledge is causing a paradigmatic change in policy-making processes (Hall, 1993).

The balance between two approaches to public health and the policies involved has been shifting in France, namely that between the traditional approach based on the biomedical model and the more recent approach, which has been gaining strength, based on public health considerations. Grounded on a study conducted in an European program², the aim of this article is to describe and explain the effects of the shift which has been occurring in France towards the public health model in the specific field of mental health policy.

From a theoretical point of view, this trend will be examined here using a cognitive policy analysis approach. As we will see, it is not only question of "solving" a problem but of constructing a new representation of the problem and taking into account the socio-political conditions under which it is addressed by society, and hence by the State (Muller and Surel, 1998). Mental health policy can therefore be regarded as a social construct including at the same time an idea of the problem in hand, a representation of the social group benefiting from the policy and a theory of social change. On these lines, a change of paradigm can be

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² Named "Know and Pol" this program is coordinated by an University of Louvain team and gather twelve research groups aiming at analysing the relation between Knowledge and Policy making in several European countries (see www.knowandpol.eu).

observed in terms of the goals of this policy and the kinds of instruments that can be mobilized to achieve them, as well as the very nature of the questions policy makers are supposed to handle.

The main hypothesis presented here is that, in response to internal pressures exerted in the field of psychiatry, along with the cost containment constraints imposed, the latest knowledge available and the need for greater knowledge, the new actors (whose legitimacy is based on their knowledge) who have arrived on the scene are transforming the shift from psychiatry to mental health into a complete change of paradigm, opening public action to actors from outside the field of psychiatry. In effect, in the declining paradigm, hospital settings, custodial practices as well as psychiatric intervention were seen as the best way to cope mental health problems in the French population. The move towards the new paradigm is characterized by an increasing use of public health data as well as more open and multidisciplinary approach to mental health. Meanwhile actors relative positions are evolving. To precise and explain how those evolutions occur at the same time in the knowledge field and in the policy making process is the aim of this article.

However, the shift to mental health from psychiatry is not a linear process. Here, the hypothesis is that each actor has to adapt to this movement, using the knowledge³ he has acquired or produced (Philippe, 2004).

By focusing on knowledge and the actors producing, using and disseminating this knowledge, the study allows to modulate the findings previously obtained in terms of governance, which suggested that the central role of the French State has decreased and that a shift of power has occurred from public policy to public action (Commaille-Jobert, 1998; Kooiman, 1993).

As we will demonstrate, the State still plays a central role in French mental health policy-making matters. This is rather paradoxical as, compared to other European countries, the French mental health policy has an actual anteriority. In effect, in France the shift toward a community based psychiatry started in the 1960's. But, today, some other countries such as Scotland or Norway are way ahead (REF K P).

However, although the French State is still in charge, its modes of intervention have changed : State representatives now have to negotiate with other actors and knowledge.

In this perspective, it will be shown how the new dynamic towards governance results in a change of legitimate knowledge. It will also be shown that knowledge and regulation tools (such as resource allocation policy) are becoming more sophisticated and less consensual than in the former period, when psychiatrists were clearly dominating.

VERIF PLAN

After a short history of the healthcare system in France and a description of its recent trends (2), it is proposed to focus on the actors (3) and the knowledge (4) involved in regulating the mental healthcare system. Lastly, the role of knowledge in hybrid forms of policy regulation, where central decision making is combined with flexible processes of adaptation, will be presented (5).

THE FRENCH HEALTH CARE SYSTEM ON GOING DYNAMICS : From Bismarck to Beveridge

The French healthcare system is basically a comprehensive health insurance system. Around the year 1945, in line with its Bismarckian roots, this system started off in the form of

³ Knowledge is not only "formal" knowledge (e.g., academic publications, epidemiological data) but also "tacit" knowledge resulting from each actor's experience (e.g. "know how").

numerous health insurance plans designed for various occupational sectors. Health coverage in France has by now become a universal and fairly equitable system. Not only 85% of the French population have a “supplementary insurance” but around the poorest 10% have this insurance paid by the State. As a whole around 20% of the health care expenses are paid by the patients and mental disease are included in the “long term disease plan”, meaning almost totally free care. In this healthcare system, relationships between physicians and patients come under the banner of freedom: physicians can practice anywhere on the French territory; in most cases, they can prescribe freely, the main restriction being that they must act in keeping with their patients’ best interests. Physicians are also free to set their own rates of payment (as long as they have opted to join Sector 2, which entitles them to set their own rates, while acting with “tact and moderation”). Patients are free to choose their own physicians and the healthcare establishments they attend. Patients can even consult specialists directly if they so wish, and until quite recently, this did not affect the price they paid for the visit. As a result, the French healthcare system is both one of the most expensive and one of the best in the world, in terms of its efficacy and equity (WHO, 2000).

In this context, the whole health insurance system has been focusing on the hospitals since the 1960s. Relatively little attention has therefore been paid so far in this country to preventive health policies and public health considerations (Bellanger and Mossé, 2005). At the top of the pyramid, the University Hospitals (CHUs) develop, improve and validate the “good practices” which are potentially applicable to the country’s whole healthcare system.

In the recent times, four major changes have occurred . The rationale of each of those changes are different but the result is that new actors are more and more involved in the regulation of the French health care system. One has to note that almost all of the on going dynamics have been pushed forward by the State in a top down process.

The first big change which occurred had to do with the funding of healthcare. Since the resources on which the healthcare and health insurance system depend are provided increasingly by income tax revenue (rather than by employees’ healthcare subscriptions), the French State and its representatives are naturally becoming increasingly involved in regulating the whole process. Since 1996, the French Parliament has been consulted about the (extent of the annual increase in collective health expenditure. This move, from a Bismarckian governance toward a Beveridgian like regulation has also be seen in other countries, although in a somehow rather controversial way (J. Van Der Zee and M. Kroneman, 2007). In France this change has been consensual and smooth. However, up to now, it is not totally effective. For instance, if the Parliament uses increasingly well-informed administrative advisers, it cannot actually afford to actually regulate the whole system.

The second important change which has recently occurred is the increasingly important role of users, who are now being called upon to adopt more responsible attitudes. This is part of an attempt to justify the fact that an increasingly large proportion of individual healthcare costs has to be shouldered by patients themselves and their families. Measures designed to increase co-payment rates and make patients shoulder part of their own healthcare and hospital bills have been adopted on these lines. Patients’ compulsory share of their ordinary healthcare expenses now amounts to about 20%, but this percentage is lower in the case of some severe pathologies, mental diseases and conditions requiring long periods of hospitalization. Apart from these economic aspects, users are also being called upon to take a more active part in regulating the country’s healthcare system. In 2002, the law on patients’ rights has facilitated patients’ access to information, and representatives of patients’ associations are now admitted to hospital administrative boards and other decision-making bodies.

The third change was the increase in the numbers of official bodies involved in healthcare as the result of the New Public Management policies adopted. In the French setting, these actors are intended to serve as mediators between the State and medical and citizens' spheres. They mobilize knowledge of various kinds and are sometimes responsible for producing this knowledge. In this way, they build up "reference" and "best practices". For example the Regional Hospitalization Agencies (ARHs⁴) were created in 1996 in each of the 26 French Regions for the purpose of regulating the public and private hospitals healthcare supply. Those bodies combine vertical planning (from National to Local level) and horizontal contracting (within local networks). Far from organizing competition as it is in quasi market systems (Belland, JJJ), those bodies aim at combining the bureaucratic power of the central Ministry and the new autonomy given to the Hospitals (GUERRERO ROGERS). Doing so they manage several kind of knowledge and involved a growing number of experts (from epidemiologists to managers).

The fourth change worth noting is that more attention is beginning to be paid to public health these days, which is something new in France. This led in 2004 to the Act on public health policy being passed. This Act was designed to reverse the tendency to give priority to the curative aspects of healthcare. It defines means of setting up a whole set of preventive and health education measures by mobilizing various actors, including citizens themselves. In addition, this Act defines a set of principles whereby knowledge in general and knowledge about assessment procedures is central to the regulation processes. Subsequent to this Act, several national Plans have been developed for setting up real public health policies on a decentralized basis. One hundred quantified indicators and the objectives to be reached have been defined in these Plans.

The Plans cover all the aspects of public health, while maintaining the balance between the administrations involved.

As far as mental health is concerned, this movement has taken a specific trend. The shift from psychiatry to mental health (Lovel, 2004) was based on a previous system of organization. In a ministerial circular dated 14 March 1990, for instance, sectorisation was promoted by inciting psychiatrists to develop contacts with healthcare professionals and those working in the medico-social field. In fact, psychiatric care has been organized on the basis of territorial "sectors"(or districts), since the 60's⁵. Each of these sectors (each consisting of about 70.000 inhabitants) is managed by an hospital Unit, which deals with the mental patients in the area, including both outpatients and inpatients.

The four changes result in two convergent processes. First there were the changes in the medical approaches used, which occurred during the 1990s : now on, psychiatrists have to work together with others specialists (social workers, psychologists...). At the same time, there was a move to place greater emphasis on economic preoccupations and to rationalize mental healthcare in line with what was going on in the rest of the French healthcare system.

In the public sector, a new resources allocation policy decreased the number of full in-hospital beds available (- 32% between 1990 and 1997) and increased the number available for daytime hospitalization purposes (+ 25%). During this period, the number of patients treated at general psychiatric wards therefore increased by 46%! (Lovell, 2004). This change imposed by the central actors was *reappropriated* in diverse ways at local level by the players in the field of mental health.

⁴ See, appendix 1 for a short description.

⁵ First ministerial circular dated 15 March 1960 launched sectorial policy. Then the psychiatric sector is recognised by the 25 July 1985 law.

It appears that a growing number of data is needed. In France as in all developed countries, most of the knowledge used to regulate the health care systems is grounded on Evidence Based Medicine (REF GGG). However, in the French Mental health field, the distrust towards EBM is strong : (REF CITATION DE DEVINEAU). As a result, the data feeding the mental health system are heterogeneous and no dominant standard exists (Demailly and Autes, 2012).

ACTORS REGULATING MENTAL HEALTH CARE SYSTEM

Titre plus “quali”

The new wave of decentralization imposed on the psychiatric healthcare system was therefore accompanied, as we have seen, by a shift of emphasis from psychiatry to mental health included public health. This change imposed by the central actors was reappropriated in diverse ways at local level by the players in the field of mental health⁶. Indeed, the 1982 decentralization law did not transfer to the local authorities any competencies in health care regulation (Biarez, 2004). Therefore, the externalisation of healthcare practices to places other than psychiatric wards had several effects. First, it led to new players (municipalities, city councils, etc.) participating in the management of public mental health policy at district level. It also favored the introduction of new instruments and new techniques for managing mental health policy.

The field of mental healthcare is now interacting increasingly with social and medico-social spheres. Now since the 80s, the regulation of the medico-social welfare supply, its institutions and its actors, has depended on local political instances such as the Departments, in particular. Locally elected representatives (in regional councils, municipalities or departments) playing a growing role in social issues (for example health preventive measures) have therefore become new players in mental health policies. Although some of the actors are typically local, others have strong links with instances at national and international levels.

This is one of the main reasons why, in 2009, the ARSs (for Health Regional Agency), replacing ARH were created to occupy an intermediate position. These bodies are “vertically” dependent on a central authority (the DHOS- Directorate for Hospitalization and the Organization of Healthcare⁷- at the Ministry of Health) as far as the framework of their activities is concerned. But at the same time, the ARS have absorbed the regional branches of the Ministry (the DRASS- Regional Direction For Medical and Social Affairs- and the DDASS- Departmental Direction For Medical and Social Affairs⁸-, as well as the Hospitals themselves). Therefore, the data and statistics that used to be DISPERSED in several local bodies are merged in a one and only regional body covering the whole range (from health to social care).

When these bodies were first created, the State started by appointing people from outside the administration as their Directors. Then after some turnover had occurred at this level, the profiles of the Directors appointed at ARHs and ARSs began to increasingly resemble those of top civil servants. Doing so, the administrative actors gained in power and legitimacy.

⁶ In a ministerial circular dated 14 March 1990, sectorisation was promoted by inciting psychiatrists to develop contacts with healthcare professionals and those working in the medico-social field.

⁷The DHOS is responsible for organising the healthcare supply, reporting to the General directorate for Health and the General directorate for Social Affairs and the Directorate responsible for National Health insurance

⁸ The DRASS and DDASS are deconcentrated regional and departmental State departments working under the authority of the French Ministry of Health: they are responsible for public health and its improvement

To face this growing power, the actors in local political spheres (the OPEPS⁹-Parliamentary Office for Health Policy Evaluation-, local Parliamentary Associations), and even Family Unions have to join forces. Of course their strategies is to increase the supply while the Government' and ARS' goal is to organize the mental health system in an efficient way. These contradictory forces and the dynamic balance between them have made the MNASM¹⁰ (Support Group in the Field of Mental Health) one of the key components of the whole regulation mechanism. Created in 1993, this is a body to which all those involved need to belong, and which in return can exert a direct influence on the central Ministry.

Among the main actors in the field of mental health, the World Health Organization Collaborative Center (WHOCC), which is based in Lille (in the north of France), plays a special role. This center, which was created in 1976, has close links with national instances, especially those depending closely on the State.

At the same time, it has direct links with locally elected and occupational representatives and with all the players involved in regulation. However, both for mental health field actors and state administration, the WHOCC legitimacy derives mainly from its acknowledgment by WHO. This Center promotes "community mental health" using the prestige it gains out of WHO expertise and label. Such a phenomenon occurred in Scotland where mental Health Policy leaders took advantage of their position in the WHO to push forward the "Flourishing Scotland GGGGG" in the 2000's (REF Freeman, HHH). But in Scotland, as in Norway or Belgium, the new mental health policy has been implemented thanks to "hearings" meaning that citizens were called to give their words, often on a micro-local basis; (ref BELGIUM). In France, even if some groups involving users were rather active, their impact on the actual policy was weak. The reason is that lay knowledge has little chance to be taken into account in a context where there is no competition among suppliers (as in the "quasi market systems) and where the "patient-client" does not pay any co-payment.

Paradoxically enough, since new actors are now entering the game, the control of public health policies is therefore mainly concentrated in Paris. In effect, most of the bodies are acting at the national level and need funds from the State administration. The following chart, resulting from empirical data gathered through interviews and official reports analysis, orders the bodies according to their centrality in the stakeholders network.

INSERT CHART 1 HERE

The crossed data collected by interviewing players on the field confirm that the central bodies responsible for the regulation and implementation of French mental health policy (the DGS -, DHOS and DGAS) all depend on the Ministry of Health.

These actors can be subdivided into 3 groups:

- the Directorates at the main Ministries responsible for implementing health policies, namely the DGS (the General Directorate for Health) and the DHOS (the Directorate for Hospitalization and the Organization of Care). These two Directorates depending on the Ministry of Health are the main bodies responsible for piloting and implementing health policies. As far as mental health is concerned, another Directorate which comes under the aegis of the Ministry of social Affairs, the DGAS (the General Directorate for Social Action), is also contributing increasingly to the change of approach described above and the advent of the mental health model.

⁹ This Office has been created in 2003 by a Law on Social Security governance (See Appendix 1).

¹⁰ The MNASM is a body responsible for providing assistance with mental health planning. Thanks to a network of correspondants and experts, it may intervene at a local level, settings local plan and helping in the mental health care organisation (see appendix1)

- Another group is that composed of ministerial Directorates which are explicitly responsible for creating knowledge and producing statistical data on health policy, in particular for MASPRAS¹¹ (a body providing Strategic Analysis, Prospection, Research and Scientific Support), which depends on the DGS.

The DRESS (the Directorate for Research, Surveys, Assessments and Statistics), which depends on another Ministry, is responsible for drawing up health-related statistics, but this organization also has other activities.

- The last group consists of decentralized Ministry of Health departments which have been set up in the regions covered by the DRASS (the Regional Direction For Medical and Social Affairs) and the departments in which the DDASS (the Departmental Direction For Medical and Social Affairs) have been implanted. Since 2009, they are all parts of the new ARS.

In this field, the relationships between actors are mostly of a hierarchical kind. This may be partly attributable to the fact that most of these bodies originated at central (or deconcentrated) administrative level. At some bodies, however, our empirical findings suggested that a tendency to move towards more organic (and therefore less hierarchical) relationships is beginning to develop, but the tendency towards more flexible, more horizontal modes of communication is mainly to be found among the local bodies.

CIRCULATION OF KNOWLEDGE AND THE REGULATION OF MENTAL HEALTH POLICY

The production and circulation of knowledge have considerable repercussions on the modes of regulation of mental health policies.

The weight of administrative knowledge

One of the specificities of this field focuses on the diffusion of knowledge: the influence of the reports commissioned by the Ministry of Health which, even if they may have no direct effects on policy making, are nevertheless consulted by policy makers and actors responsible for implementing public policies and producing knowledge. These reports could be said to serve as knowledge milestones.

The importance of the knowledge on which administrative, hierarchical and planning activities are based in France is still very great. In addition, the various actors (apart from the divergences observed in terms of their interests, knowledge and points of view) have integrated this fact and take it into account when planning their action and their strategies: this actually contributes to increasing the impact of the knowledge produced by administrative bodies for administrative purposes.

Indeed, strong conflicts and controversies have arisen about the change of paradigm ("from psychiatry to mental health"), for example. But the challenge focusing on the autonomy of a given body with respect to the central bodies is always an essential point. This no doubt explains why the multiple positioning of some actors (which in itself is a fairly classical situation) is of special importance here: it is necessary for actors to keep right in the mid-stream of the circulating information and administrative data in order to know the rule of the game (e.g. resource allocation criteria).

In this context, innovative practices are often adopted at the instigation of the actors on the field.

¹¹ MASPRAS is responsible for producing knowledge in the field of healthcare.

Local micro networks mediating the circulation of knowledge

A survey carried out on the Nord Pas de Calais psychiatric sector (Maury, Mossé, Roelandt, Daumerie, 2007) shows the importance of highly localized interactions and that of micro networks of individuals, not only in terms of the acquisition of knowledge by these individuals, but also in terms of the diffusion of this knowledge. In cases where nationally produced knowledge which is diffused via centrally organized channels (such as the MNASM Newsletter and reports and the HAS recommendations) does not reach the actors targeted, the fact that they encounter other actors involved in the production or diffusion of this knowledge can be of great importance.

The case of locally elected representatives and political figures is particularly interesting in this respect. Upon analyzing the interviews conducted with these people, the following conclusions were drawn:

- These actors constitute a particularly homogeneous group in terms of their picture of the field of mental health. The locally elected political representatives all had very similar ideas, whereas the other groups interviewed had very heterogeneous representations of mental health¹².
- In addition, these locally elected political figures' views linked up with those of other actors, and this finding provided us with a promising approach, which seemed to indicate that the locally elected figures serve as "brokers" relating heterogeneous elements to each other.

It is worth noting in addition that knowledge produced directly by the users of mental health policies themselves is circulated in local micro-networks. This trend is occurring concomitantly with a sharp increase in the knowledge available about the community approach to mental health, which is being diffused among professionals in the field of psychiatry. In this approach to mental healthcare, the success of the treatment depends to a large extent on the contribution of the patients themselves and that of their families. In this framework, patients' experience of their own symptoms and disease (or in the case of UNAFAM, the symptoms and disease of a member of their family) amount to competences on which the actors base their discourse, their action and their knowledge.

Accountability and flows of knowledge

The present findings show, however, that the formally instituted top-down knowledge transmission circuits are not functioning completely satisfactorily. Little use of figures transmitted by HAS is made by local actors, heads of sectors, healthcare establishments and locally elected political ; whereas the knowledge involved in the budgetary rules obliging establishments to comply with a number of criteria (especially in terms of efficiency, i.e., accountability) has circulated quite successfully. Knowledge seems in fact to circulate more efficiently when it serves to obtain funds (or not) and when it is integrated into administrative circles.

Accountability therefore practically obliges the territorialized actors to take centrally produced knowledge into account. In the case of HAS, the procedures involved in the accreditation of healthcare establishments include a set of compulsory objectives: failure to comply with these objectives leads to the funds allocated being reduced. As a result, knowledge circulates efficiently between the national level at which it is produced and the territories where access to State funding depends on this knowledge being applied.

¹² The empirical data on which this paper was based consisted of data published by the various bodies cited here and 40 semi-directive interviews (15 with representatives of national bodies and 25 at local level. The interviews were analysed using the Alceste discourse analysis software program. For more complete analysis, see Maury et al, 2007, pp. 27 – 31.

This process of circulation is both hierarchical and involves relatively restricted targets. Therefore, contrary to New Public Management theories market mechanisms do not interfere (Barzelay, 2001). Only a very small proportion of this knowledge is used by the actors for horizontal competition purposes. When competition of this kind does occur, it is in a quasi-fictive form as most of medico-economic data are used in a benchmarking process.

All in all, the new instruments of healthcare policy regulation, which have led in the case of mental health to sectors being replaced by healthcare territories, depend closely on a set of knowledge which is all the more successfully integrated when it has concrete effects in terms of regulation.

Data and knowledge in the epidemiological sphere provide a particularly good illustration of this process : during the interviews, all the actors involved (in GIS psychiatry, in the 2004 French Healthcare Act, and the Psychiatry and Mental Health plan) have stressed the lack of data available in the field of French psychiatric epidemiology and the need for further studies. Obtaining new kinds of knowledge in the field of psychiatry is a fundamental objective for all the national bodies involved, since not only accountability but also the regulation of mental health policies throughout the country depend on the existence of this knowledge and its accessibility.

As far as the creation and diffusion of knowledge is concerned, the WHOCC serves mainly as a relay promoting the recommendations of WHO in France. This is the main purpose for which this body was created, especially in the fields of research and education, as well as that of medical experimentation. It therefore promotes the policies adopted by WHO in favor of what is known as “community psychiatry”. In parallel, the WHOCC reports to the WHO specialists on the situation in France

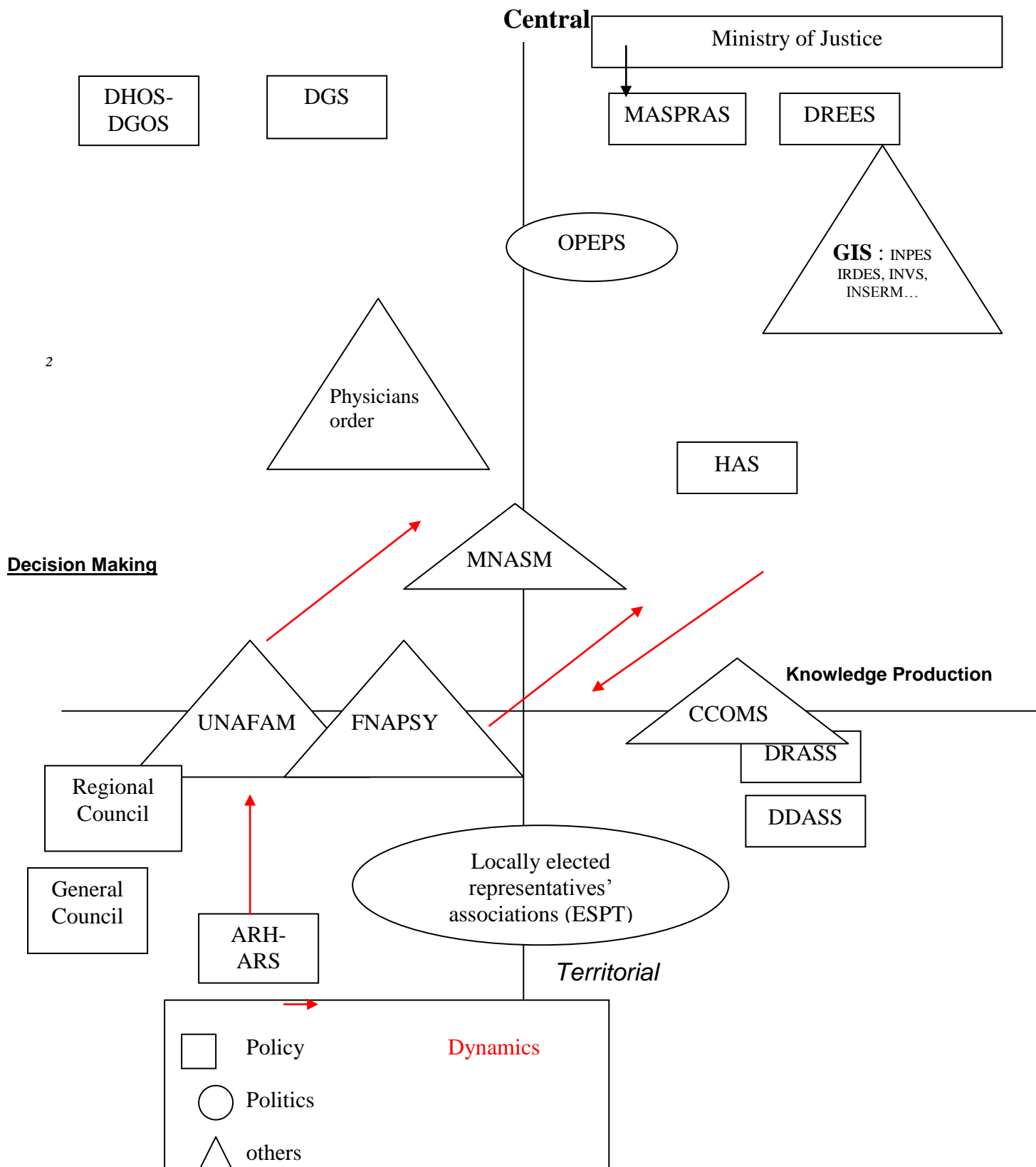
The main WHO report on Mental Health policy, which is known as the Helsinki report, was published in 2005. This report focused on defining an “action plan” for the years to come. It also proposed a set of indicators for implementing “mental health community” policy in European countries. These indicators were not specifically included in subsequent French mental health policies but inspired the Plan published in 2005. In addition, since 2000, the recommendations published in the WHO report have been used as benchmarks by French mental health policy makers. In a study carried out by the French Ministry of Health, the aim was explicitly defined as that of comparing the current French situation with the recommendations of the WHO experts.

THE ROLE OF KNOWLEDGE IN HYBRID FORMS OF POLICY REGULATION

A figure has been drawn to illustrate the links between actors and knowledge which are involved in the change of approach. Resulting from interviews with protagonists and enlightened by the cognitive policy theory, this figure is organized around two axes.

On the main axis, the bodies which carry out their activities at central level are opposed to those located at more decentralized levels. On the second axis, bodies which produce or use knowledge of a more academic kind are opposed to those where the knowledge mobilized or required is of a more operational, decision-making and policy-making kind. In addition, to specify what types of bodies are involved, a special notation has been used to indicate the actors’ logics, i.e., whether they are oriented towards “policies” or “politics”, and those located at interfaces or subscribing to the private sector’s logics (see the legend to diagram 1). This figure also gives some hints about the diachronic aspects . In those cases where our analysis has shown that a body is moving along one of the axes, this is indicated by an arrow marked “dynamics”.

FIGURE 1 :



On the main axis, we have shown the bodies which carry out their activities at central level are opposed to those located at more decentralised levels. On the second axis, we have included bodies which produce or use knowledge of a more academic kind are opposed to those where the knowledge mobilized or required is of a more operational, decision-making and policy-making kind. In addition, to specify what types of bodies are involved, a special notation has been used to indicate the actors' logics, i.e., whether they are oriented towards "policies" or "politics", and those located at interfaces or subscribing to the private sector's logics (see the legend to diagram 1).

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Novel modes of public action initiated by territorial actors

Since a highly centralized bureaucratic model still persists in France, some typically "governance-related" characteristics can be observed: these are to be found at the territorial level. The move to decentralize and delegate responsibility which was initiated at central level in 1982 was not the main reason for the emergence of a hybrid form of mental health policy regulation combining centralized decision making¹³ with flexible adaptation at the local level. At the latter level, the actors (including those working at decentralized administrations such as DRASS and DDASS) are basing their action less on administrative segmentation considerations than on the scale on which problems occur and have to be solved. This type of local adaptation of national dispositions actually has feed-back effects on national policies, since these have to re-integrate local initiatives into the overall scheme. The MNASM plays a fundamental role in this respect, as this body sends the information collected on the field (at monthly meetings with mental health departments depending on the DGS -Bureau II- at the DHOS and the DGAS) upstream to the central bodies. The professional trajectories of some actors seem to accurately reflect these interactions between national and territorial levels.

DISCUSSION

The results of the present study show that the change of approach, i.e, the change of paradigm from psychiatry to mental health, has been accompanied by changes in the respective roles of the players involved in regulation. At the same time, the type of knowledge developed by the players, which circulates among the various players, has changed. The accent is now being placed on accountability and transparency, which is partly based on classical psychiatric knowledge, and the fact that these aspects are now being taken into account has changed this knowledge in the following two ways. On the one hand, the economic, statistical and financial factors have actually become central to the new approach and on the other hand, as the players liable to circulate new knowledge are becoming increasingly numerous, this knowledge is liable to become increasingly heterogeneous. However, the findings show that we may be dealing with another "French exception". In many industrialized countries, the introduction of the New Public Management (NPM) approach has enhanced competition, market logics and the privatization of health care (Woods, 2002), whereas in France, although the NPM approach has developed as fast as elsewhere, far from favoring only market logics, it has resulted in the reinforcement of the central administrative structures. In the context of French society as a whole, the NPM approach has not led to a process of rationalization

¹³ cf. the role of the Ministry of Health

mobilizing various forms of direct competition between health care providers. The NPM is serving on the contrary as a tool for planning mental healthcare, especially at regional level. Although the conclusions we have reached here will have to be tested by performing further empirical studies, they can be expressed as follows: even if the new paradigm is yet to be, it already reveals the strength of an Administration that is able to increase its power while opening itself. Therefore, in the development of French healthcare policies, the legitimacy of the involved actors is decisive. As a result, the effectiveness of the knowledge mediating by actors depends on its usefulness in the dialogue with the State administration.

Appendix 1

ARRH : Regional Agency for Hospitalization.

ARRHs are public interest groups involving the State and national health insurance organizations, under the aegis of the Ministries in charge of Health and Social security. Their purpose is to decentralize the organization of public and private hospitalization. In 2010, ARRH's have been changed in ARS (Regional Agency for Health).

DDASS : Departemental (County) Direction For Medical and Social Affairs

DDASS and DRASS are at, deconcentrated regional and departmental State services under the aegis of the French Ministry of Health: they are responsible for public health and its improvement

DHOS : Directorate for Hospitalization and the Organization of Healthcare

The DHOS is responsible for organising the healthcare supply, reporting to the General directorate for Health and the General directorate for Social Affairs and the Directorate responsible for National Health insurance. Recently changed in "DGOS" for Directorate for Health Organization)

DRASS : Regional Direction For Medical and Social Affairs (see DDASS)

DGS : General Directorate for Health (Ministry of Health).

The DGS is responsible for drawing up and implementing public health policy

DREES : Directorate for Research, Surveys, Assessments and Statistics

The DREES, which depends on the Ministries of Health and Social Affairs, is responsible for producing useful statistics for the Ministries and social players

FNAPSY : a Mental Health Patients' Association

GIS : Scientific Interest Group in psychiatry

This Group, which was created at the initiative of the Ministry of Health, promotes the development of clinical and epidemiological research in the fields of psychiatry and mental health in France.

HAS : French National Authority for Health

HAS is an independent public body which enjoys financial autonomy, and is in charge of improving the quality of patient care and ensuring equity within the French healthcare system.

MASPRAS : A body providing Strategic Analysis, Prospection, Research and Scientific Support

This unit, which depends on the DGS at the Ministry of Health, is responsible for producing knowledge in the field of healthcare.

MNASM : A national body providing Support in the Field of Mental Health

Its missions are three-fold: planning, providing central administrations with expertise, and communication and information.

OPEPS : (Parliamentary Office for Health Policy Evaluation)

A parliamentary commission consisting of deputies and senators who inform the Parliament about the possible effects of its decisions in the field of mental health.

UNAFAM : an Association representing mental patients' families

REFERENCES

- Barzelay M. 2001. *The New Public Management*, Russel Sage Foundation, 238 p.
- Bellanger M. and Mossé P. 2005. The search for the Holy Grail: combining decentralised planning and contracting mechanisms in the French health care system », *Health Economics* 14: S119–S132.
- Biarez S. 2004. Une politique publique : La santé mentale (1970-2002), *Revue Française d'Administration Publique*, 111 : 517-531
- Borins S. 2000. New Public Management, North American style, in McLaughlin, Osborne, and Ferlie, eds., *The New Public Management: Current Trends and Future Prospects*, Chapter 13.
- Commaille J., Jobert B. 1998. *Les métamorphoses de la régulation politique*, Paris, LGDJ
- Evans P., Rueschmeyer D., Skocpol T. 1985, *Bringing the State Back In*, Cambridge University Press.
- Hall P.A. 1993. Policy Paradigms, Social Learning and the State. The Case of Economic Policymaking in Britain, *Comparative Politics*, 25, 3 : 275-296
- Hurst J and Jee-Hughes M. 2001. *Performance measurement and performance management in OECD health systems*, Oecd paper, N° 47, 67 p.
- Jones C.O. 1972. *An introduction to the study of public policy*, Wadsworth publishing
- Kooiman J. 1993. *Modern Governance*, Sage
- Lovell A. 2004. *Santé mentale et société*, Paris, La Documentation française
- Maury C., Mossé Ph., Roelandt J-L, Daumerie N. 2008. *Mental Health in France. Policies and actors. Toward a more open administration*, Research report (Orientation 1) for Know and Pol research (European 6th PCRD), available on www.knowandpol.eu
- Milbank Memorial Fund. 2000. *Effective Public Management of Mental Health Care*, May, 125 p.
- Muller P., Surel Y. 1998. *L'analyse des politiques publiques*, Paris, Montchrétien
- Philippe S. 2004. La mise en œuvre de l'action publique : un moment problématique. L'exemple de la santé mentale, *Revue française de Science Politique*, 54, n°2 : 315-334
- WHO, (2000), *The World Health Report 2000 – Health systems: Improving performance.*, 202 p.

Woods K J. 2002. *A critical appraisal of accountability structure in integrated health care systems*, September 2002, Glasgow, 34 p.

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Chart 1 Centrality and relationships

